your health
NETWORK
A NEWSLETTER FOR ALL STATE GROUP INSURANCE PROGRAM PARTICIPANTS
December 2005 Volume 13, Number 2

inside

What Is a Self-Insured Health Plan?

In correspondence you receive from the Division of Insurance Administration, you will often see the state-sponsored healthcare options referred to as "self-insured." But just what does self-insured mean?

The benefits and premiums for all healthcare options are set by the State, Local Education and Local Government Insurance Committees. The state does not simply purchase an off the shelf insurance product. The insurance companies that administer claims for the PPO, POS and HMO (BlueCross, Cigna, John Deere) are selected based on a competitive procurement process which evaluates a set of qualifications such as network composition and distribution, claims processing ability, capability to assist in managing medical treatment and administrative fees. The Division of Insurance Administration is responsible for administering and/or overseeing all components of the group insurance coverage on behalf of the committees.

The self-insured status means claims are paid from funds collected and maintained by the state, which consist of employee premiums and your employer's contributions (if applicable) on your behalf. By being self-insured, the state assumes the financial risk and is responsible for collecting an adequate amount of money to pay for all medical claims submitted. Additionally, by being self-insured, we lower our overall expenses, resulting in lower costs to members.

The state contracts with administrative service organizations to carry out specific functions. These companies process claims based on the rules set forth by the insurance committees for which they are paid an administrative fee. Administrative costs represent about 8 percent of total plan expenses while claims payments represent about 92 percent.

Every year, the insurance committees review claims expenses and utilization trends to determine how much money must be collected to adequately fund the following year's benefits. We often hear, "why do you keep raising my monthly premium?" — the answer is simple — as more medical services are used by participants and as the cost of these services continues to increase, we must collect adequate funds to ensure that the costs for medical services used by plan participants are covered.

Medicare Part D Pharmacy Plan and Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the state-sponsored healthcare options (PPO, POS and HMO) and the new prescription drug coverage available January 1, 2006, for people eligible for Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage. This notice applies to you and your covered family members who are eligible for Medicare. Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. The insurance committees have determined that the prescription drug coverage offered under the state-sponsored healthcare options is, on average for all plan participants, expected to pay out in benefits as much as the standard Medicare prescription drug coverage will pay. Read this notice carefully—it explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll.

You may have heard about Medicare's new prescription drug coverage, and wondered how it would affect you. Starting January 1, 2006, prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

The insurance committees have determined that your prescription drug coverage offered under the PPO, POS and HMO healthcare options is, on average for all plan participants, expected to pay out in benefits as much as the standard Medicare prescription drug coverage will pay.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

People with Medicare can enroll in a Medicare prescription drug plan from November 15, 2005, through May 15, 2006. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year after that you will have the opportunity to enroll in a Medicare prescription drug plan between November 15 through December 31.

If you decide to enroll in a Medicare prescription drug plan and drop your state-sponsored health coverage with prescription drug coverage, be aware that you may not be able to get this coverage back.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you ***will not*** still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan. You should also know that if you drop or lose your coverage through the state and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If, after May 15, 2006, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium for Medicare Part D will go up at least 1 percent per month for every month after May 15, 2006, that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact our office for further information. NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You may also request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage will be available in October 2005 in the *Medicare and You 2006* handbook. You will receive a copy of the handbook in the mail from Medicare if eligible. You may also be contacted directly by Medicare prescription drug plans. You can get more information about Medicare prescription drug plans from the following sources:

- Visit www.medicare.gov for personalized help.
- Call your state health insurance assistance program. If you live in Tennessee call 1.877.801.0044. Refer to the *Medicare and You* handbook for other numbers.
- Call Medicare at 1.800.633.4227 (TTY 1.877.486.2048). For people with limited income and resources, extra help is available from the Social Security Administration. For information about this extra help, visit www.socialsecurity.gov or call 1.800.772.1213 (TTY 1.800.325.0778).

Remember, keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

notable

Under the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy (including lymphedema). If you have questions about this act, please call the toll-free telephone number listed on your member identification card.

When adding or cancelling coverage for a dependent, please remember to do so in a timely manner. To add coverage for a newly acquired dependent, an application must be completed within 60 days of the date a dependent is acquired. When you request cancellation, a dependent's coverage will terminate on the last day of the month in which the dependent looses eligibility.

The insurance comparison brochure mailed to all participants during this year's annual transfer period contained an error in the dental benefit chart for the PDO option. Under removal of impacted tooth (complex oral surgery) the benefit was listed as 80% of MAC for in-network and 60% of MAC for out-of-network — the correct benefit level is 50% of MAC for either in-network or out-of-network.

With the change in claims administrators for the POS and HMO beginning in 2006, those individuals participating in a disease management program through the BlueCross or John Deere POS and the Aetna HMO will no longer be eligible to participate under the same claims administrator. Cigna will work with the appropriate staff for the exchange of data that identifies the membership and diagnosis information. If you continue your coverage, you will be contacted by Cigna just after the first of the year regarding their disease management program.

Make Sure to Add New Dependents Timely

Important events in your family can affect your healthcare coverage. It is very important that you take the correct steps to update your coverage immediately should you experience a life change such as marriage, or the birth or adoption of a child.

An enrollment/change application must be completed within 60 days of the date a dependent is acquired. The "acquire date" is the date of birth, marriage, or, in the case of adoption, the legal obligation and support of such child. Changes in type of coverage (single to family) are effective on the first day of the month in which the dependent was acquired, or, if requested, the first of the following month. (If you maintained family coverage on the date the dependent was acquired, the effective date may be retroactive to the dependent's acquire date even if beyond the 60-day enrollment period.)

If dependents are added while you are on single coverage, you must request family coverage for the month the dependent was acquired in order for claims to be paid. This change in type of coverage is also retroactive and you must pay for family coverage for the entire month. If paying claims is not an issue, you may choose the subsequent month for the effective date.

If you have single coverage and do not notify your insurance preparer within 60 days of acquiring a dependent, the new dependent can only enroll if they meet one of the special enrollment provisions or by qualifying through the late applicant medical underwriting process.

If a dependent becomes ineligible, it is your responsibility to notify your insurance preparer. You are liable for any claims for benefits received by an ineligible dependent.

Changes in Medicare Supplement Coverage

The Medicare Modernization Act made significant changes to Medicare and to the rules that govern Medicare supplement coverages. It also authorizes Medicare Part D which provides prescription drug coverage. There are also restrictions on the benefits that can be provided by Medicare supplement policies. Consequently, beginning January 2006, the Medicare supplement policy offered by the State of Tennessee will no longer provide for a pharmacy benefit. Beginning in 2006, the state will only offer one Medicare supplement policy—The Tennessee Plan—with benefits equal to the current Plan One offering.

Enrollment in a Medicare supplement policy is designed specifically to fill in the gaps in Medicare coverage. What kind of gaps? For instance, Medicare requires you to pay a $952 deductible out of your own pocket each time you are hospitalized. Then $238 a day for the 61st through 90th days of a lengthy hospital stay. You must also pay 20 percent of approved medical expenses. Enrollment in supplemental coverage fills in these Medicare gaps in coverage.

One of the main advantages of the Tennessee Plan is the lower group premium rates for coverage. If you qualify and enroll within 60 days of the date of your initial eligibility, you cannot be turned down for this coverage because of your age and health. Even better, if you are a retired state employee or teacher with 15 years or more of service, the state will pay part of your monthly premium.

If you retire, once you become entitled to Medicare (age 65) you can no longer retain health coverage under the PPO, POS or HMO. Medicare supplement coverage is designed to work with Medicare and help you offset your out-of-pocket costs for care.

The SAD Season

Like many people, you may experience cabin fever during the winter months. Or, you may tend to eat and sleep more when the temperature drops. But, seasonal affective disorder (appropriately referred to as SAD) goes well beyond those symptoms. SAD is much more than the winter blahs. It's a type of depressive disorder.

Exactly how many people have SAD isn't really known, but it's estimated that about 6 percent of Americans suffer from winter SAD, and another 10 to 20 percent may experience mild SAD symptoms. The disorder usually begins when you're a young adult and is more common in women than men. Symptoms of SAD most often begin in the fall or winter and then subside in the spring. If you regularly experience the following signs and symptoms when the seasons change, you may have SAD:

- Moodiness (depressed, sad or unusually quiet).
- Loss of energy and fatigue.
- Reduced interest in daily activities.
- Increased sleep and sleepiness.
- Increased appetite and craving for carbohydrates (such as pasta, bread and sweets).
- Weight gain.
- Difficulty concentrating and processing information, especially in the afternoon.
- Full remission from depression in the spring and summer months.
- Symptoms of SAD keep coming back year after year at about the same time.

Doctors don't know the causes of SAD, but heredity, age and your body's chemical makeup all seem to play a role. So can the availability of sunlight. Some scientists have theorized that melatonin, a sleep-related hormone that's also linked to depression might be the cause.

There are several things you can do to help you cope with seasonal depression.

- Increase the amount of light in your home. Keep curtains opened and shades up. Spend as much time as you can in the brightest part of your home or office.
- Get outside. Walk outdoors on sunny days, even during winter. You can increase your exposure to daylight by getting up early.
- Exercise regularly. Physical exercise helps relieve stress and anxiety, which can accentuate SAD.

Don't Let the Holidays Get You Down

While the holiday season is a time of joy, the extra pressures and stresses of preparations and gatherings can cause stress and even bouts of depression. To follow are a few tips from the EAP to help your holidays be successful.

- Keep expectations reasonable and manageable.
- Plan activities ahead of time and don't commit yourself with too many obligations.
- Get proper sleep and rest to avoid exhaustion and irritability.
- Exercise and avoid excessive eating.
- Let go of the past. Don't expect the holidays to be perfect.
- Plan pleasurable activities for the future to avoid end of the season feelings of depression.
- Find time for yourself and do things you enjoy.

If you have a feeling of hopelessness, helplessness or sadness, call the EAP at 800.308.4934 for help. You may talk with a professional counselor confidentially. A new anonymous depression and alcohol screening is available toll free at 866.249.1580. You may also take a self-assessment test for stress and depression online at www.magellanhealth.com — use the telephone number (800.308.4934) to enter the site as a registered or unregistered member.

Dependent Child Eligibility Audit

Earlier this year, an audit was conducted of dependents insured under the category of a child tax dependent. The audit was to determine if the child was eligible for coverage during 2004 as the employee indicated. A total of 2,571 child tax records were audited and, of these, 35 percent did not qualify for coverage under any definition of dependent. Because this was the first audit of its type, the plan granted amnesty to those employees who were insuring a non-eligible child and no claims payments were recouped.

During 2006, the division plans to conduct an audit of stepchildren as well as child tax dependents due to a number of stepchildren identified and listed as child tax dependents that did not meet any eligibility criteria of the plan. During this audit, the division will be determining the exact date on which a child tax dependent may have lost their eligibility. Any claims payments made on these ineligible dependent's will be recovered.

Please refer to your Insurance Handbook for information on dependent eligibility guidelines. If you are insuring a child who no longer meets the eligibility guidelines, contact your agency insurance preparer to terminate the coverage immediately.

Cigna POS and HMO Transition

As communicated to plan participants during this year's annual transfer period, Cigna HealthCare will be the new claims administrator for the HMO in the Nashville and Memphis service areas and the POS statewide effective January 2006. This article addresses several concerns expressed by plan participants during the transfer period.

Benefits

Other than a decrease in the copay for maternity care under the POS and the addition of chiropractic care for both the POS and HMO, there is no change in the benefit structure.

Referral Process

For POS participants, a primary care physician selection is not required. There is also no referral requirement to see a specialist provider in the Cigna network. While the POS does offer the ability to seek services from an out-of-network provider, please remember that your out-of-pocket cost will be substantially higher.

Mail-at-Retail

Cigna is currently working to establish a "mail-at-retail" network where individuals can obtain a three-month supply of maintenance medications for one copay at retail locations rather than using the mail order program. At the time of this newsletter's printing, the following chain pharmacies had agreed to participate.

- Freds
- Kmart
- Kroger
- Publix
- Rite Aid
- Sam's Wholesale
- Schnucks
- Super D
- Wal-Mart

For the most up-to-date listing, please refer to the "quicklinks" page of the division's website.

Prescription Transfer

For continuing pharmacy needs, a new prescription will not be required. For a refill at the retail pharmacy that is participating in the Cigna network, simply show your Cigna ID card to receive your prescription. For mail order maintenance medications, you can use the QuickSwitch program (outlined in your member handbook) which entails one phone call to Cigna. Just provide your information and Cigna will take care of the rest, including contacting the doctor to validate the prescription. The process is very easy, but you should be sure to call before you run out of the medication as sometimes it can take a week or more just to get in touch with the physician to obtain the required information.

Out-of-Area Program

If you will be located outside of the service area for an extended period of time, or if you have a dependent attending college outside the state, Cigna offers the Guest Privileges Program. With this program, you or your covered dependent can receive in-network benefits from a participating provider if they are located in an area where Cigna has a network. Please refer to your member handbook or contact Cigna member services for more information.

Late Applicant Process Continues for 2006

Under the 1996 Federal Health Insurance Portability and Accountability Act (HIPAA), group health plans must generally comply with the requirement of non-discrimination against individual participants and beneficiaries based on health status. However, the law also permits state and local government employers that sponsor health plans to elect to exempt a plan from these requirements for self-funded options. All of the state-sponsored health options are self-funded; therefore, the State of Tennessee has elected to exempt the plans from the prohibitions against discriminating against individuals and beneficiaries based on health status in order to allow medical underwriting through a late applicant process.

By requesting this exemption, the state-sponsored plans will be able to continue the process that allows an eligible individual, who is not presently enrolled (late applicant), to enroll in the plan through a medical underwriting or proof of insurability process. The exemption from this federal requirement will continue for the plan year beginning January 1, 2006, and ending December 31, 2006. The election may, but is not required to be, renewed for subsequent plan years.

Eligible employees may apply for coverage for themselves and/or their eligible dependents by submitting medical information about each applicant. Employee eligibility must be verified by the employing agency and a non-refundable application fee is required. Applications may be obtained from your agency insurance preparer or you may print a copy from our web site at www.state.tn.us/finance/ins/.

This enrollment process is in addition to the special enrollment provision process for those who lose their health coverage due to a HIPAA qualifying event. Please see your *Insurance Handbook* for a list of qualifying events. In these instances, the medical underwriting process is not necessary. The special enrollment provisions require that application for coverage be made within 60 days of the qualifying event by submitting the appropriate forms and documentation.

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December 2005 Volume 13, Number 2

Tennessee Department of Finance and Administration. Authorization No. 317299, December 2005, 150,000 copies. This public document was promulgated at a cost of $0.05 per copy. Contact the editor if you require this publication in an alternative format.

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